and disappointing when the insurance plan has a pitiful number of hungry, second-rate specialists to refer to.

Keep writing—I've always admired your work.

WILLIAM W. JOHNSON, MD
15266 Via Pinto
Monte Sereno, CA 95030

REFERENCE

1. Watts MSM: Primary care—Does it have a future? (Editorial). West J Med 1987; 146:613

Where Is the Pathologist?

TO THE EDITOR: The editorial by Helen Ranney, MD, in the April 1987 issue[1] seems to support the thesis that the data generated by electronic hematologic counters make examination of the peripheral blood smear less necessary, and when morphologic examination might be required, a medical technologist could best perform this function. A glaring omission in the process is the role of the pathologist. In most hospitals, smears generated from electronic counter abnormalities using preset criteria are reviewed by the pathologist. This is really the vital link between the laboratory and the clinician, assuring that significant data do not become "lost" in the ever-growing laboratory section of the chart.

Although electronic counters are excellent screening tools that are continuing to revolutionize the field, they have limitations and many abnormalities need confirmation by blood smear examination. The hematologists who practice at our institution never fail to stop off in the laboratory to review the smear before visiting their patients.

C. JACK BARK, MD
Director of Laboratories
Alvarado Hospital Medical Center
6655 Alvarado Road
San Diego, CA 92120

REFERENCE

1. Ranney HM: Clinical evaluation of anemia (Editorial). West J Med 1987 Apr; 146:473-474

* * *

Dr Ranney Responds

TO THE EDITOR: I apologize for the incorrect reference given in my editorial, "Clinical Evaluation of Anemia."[1] The first reference should have been the study by Jen and co-workers.[2] In that study, examination of the blood smear was "no better than the red blood cell indices in detecting probable iron deficiency or low serum levels of folate or vitamin B_{12}. In anemias not caused by deficiency states, the blood smear reading performed by the hospital laboratory provided unique information in 6 percent of the cases and helpful information in another 25 percent. But the additional reading performed by a hematologist never provided unique information and provided incremental helpful information in only 4 percent of the cases." The authors conclude that, in their hospital, "a routine personal reading by a physician had limited incremental value and could be reserved for selected cases," notably, the confirmation of platelet counts and evaluation of abnormal leukocyte counts or leukocyte morphology. Most physicians would agree with those authors that physicians should review the blood smears in selected cases, such as in severe cases of hemolytic anemia, anemia of uncertain cause even after evaluation, anemia in which a patient unexpectedly fails to respond to treatment or anemia associated with abnormal white cells either in number or morphology. Because these patients are frequently referred to hematologists, many internists leave the slide review to the hematological consultant.

In many teaching hospitals there are one or two senior, often supervising, medical technologists who have developed great proficiency in analyzing blood smears. Perhaps such technologists were involved in the study cited. Such respected names in American hematology as Geneva Daland, who was associated with W.B. Castle, MD, and coauthored a book with him, and Virginia Minnich, who worked for many years with Carl Moore, MD, are examples of medical technologists whose skills in smear interpretation were greater than the skills of many hematologists. Technologists with such skills provide excellence to a laboratory. Like Dr Bark, I think that most hematologists continue to examine blood smears. The cost of laboratory work might be reduced, however, by allowing the referring physician to designate the desired reviewer of the smear, that is, a hematologist or pathologist would review only on specific request.

HELEN M. RANNEY, MD
Professor of Medicine
University of California, San Diego, School of Medicine
Distinguished Physician
Veterans Administration Medical Center
3550 La Jolla Village Dr, 11F
La Jolla, CA 92161

REFERENCES

1. Ranney HM: Clinical evaluation of anemia (Editorial). West J Med 1987 Apr; 146:473-474

2. Jen P, Woo B, Rosenthal PE, et al: The value of the peripheral blood smear in anemic inpatients—The laboratory's reading *v* a physician's reading. Arch Intern Med 1983; 143:1120-1125

Wright's Law Is Right on

TO THE EDITOR: Bravo! And thank you for publishing the absolutely brilliant "Wright's Law" in the June 1987 issue.[1] Wright is right. Economics writes history (contemporary US medical history, that is). Right on, Wright.

GARY GORLICK, MD, MPH
6221 Wilshire Blvd
Los Angeles, CA 90048

REFERENCE

1. Wright ES: Wright's law (Correspondence). West J Med 1987 Jun; 146:749

Insects in the Operating Room

TO THE EDITOR: Reports of insects in the operating room, while not common, have been described in patients with poor hygiene and who have not showered prior to their same-day operation.[1] When dealing with the ubiquitous insect world, it must be remembered that one's personal hygienic habits do not necessarily protect against bringing insects into the operating room.

A case in point is that of a 30-year-old man who was brought to the University of California, Davis, Medical Center—a major trauma center for northern California—after being involved in a serious roll-over motor vehicle accident; apparently paramedics found him lying in a field off the side of the road. Several hours into the surgical debridement and repair of the patient's open right humeral fracture and brachial artery laceration, an insect was noted crawling out from under the sterile drapes, towards the wound. The trespasser was arrested by the surgical technique known as "squashing," and was sent to the pathology department for identification.